BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

FRANKIE S. KEELER Claimant	)	
VS.	)	
SPEARS MANUFACTURING CO. Respondent	)	Docket Nos. 1,029,602 & 1,029,603
AND	)	
ZURICH NORTH AMERICAN INS. CO. Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Both claimant and respondent and its insurance carrier (respondent) requested review of the January 21, 2010, Award entered by Administrative Law Judge Thomas Klein. The Board heard oral argument on April 21, 2010. William L. Phalen, of Pittsburg, Kansas, appeared for claimant. Kendall R. Cunningham, of Wichita, Kansas, appeared for respondent.

In Docket No. 1,029,602, the Administrative Law Judge (ALJ) found that claimant was permanently totally disabled. In Docket No. 1,029,603, the ALJ found that claimant had no permanent disability from his exposure to aerosolized oil.

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

In Docket No. 1,029,602, respondent contends that claimant's current condition is not the result of his accident at work on May 8, 2006. Respondent argues that claimant is not credible and is not permanently totally disabled as a result of the May 8, 2006, accident. In Docket No. 1,029,603, respondent asks that the Board affirm the award of the

ALJ finding that claimant has no permanent disability from his claimed sensitivity or allergy to oil.

Claimant asks the Board to affirm the ALJ's finding that he is permanently, totally disabled as a result of the May 8, 2006, accident. In the event the Board reverses the ALJ's award of permanent total disability, claimant requests that the Board find that he suffered permanent impairment due to exposure to oil as well as a work disability from the injuries suffered in the accident on May 8, 2006.

The issues for the Board's review are:

(1) Are claimant's current medical and/or psychological conditions the result of his work-related injury on May 8, 2006, as claimed in Docket No. 1,029,602?

(2) If so, what is the nature and extent of claimant's disability in Docket No. 1,029,602?

(3) Did claimant suffer injury and disability as a result of his exposure to oil at work on June 9, 2006, and each and every working day thereafter?

(4) If so, what is the nature and extent of claimant's disability in Docket No. 1,029,603?

FINDINGS OF FACT

Claimant has two workers compensation claims. On June 23, 2006, claimant filed an Application for Hearing claiming he suffered injuries to his "[h]ead and all other parts of the body affected" while operating a forklift on May 8, 2006.[1] The same day, claimant filed a second Application for Hearing claiming he suffered injuries to his "Pulmonary, Respiratory Systems and all other parts of the body affected" as a result of exposure to "oil, oil fumes, and chemicals" "[e]ach and every working day beginning 06/09/06 and continuing."[2]

Docket No. 1,029,602; May 8, 2006 accident (forklift)

Claimant testified that in 2001, before he started working for respondent, he suffered from headaches. He was treated by Dr. Eustaquio Abay. Dr. Abay discovered that claimant had an arachnoid cyst in his brain, and on January 18, 2002, he performed a cranial cyst-to-peritoneal shunt placement. The shunt drains fluid from claimant's brain into

[1] Form K-WC E-1, Application for Hearing filed June 23, 2006. (Docket No. 1,029,602)

[2] Form K-WC E-1, Application for Hearing filed June 23, 2006. (Docket No. 1,029,603)

his stomach. Claimant testified that he was headache-free after this surgery until his May 2006 accident.

On May 8, 2006, claimant was operating a forklift at work when he accidently loaded too much material onto the forklift. Claimant said that when he backed the forklift away, the forks of the forklift were forced down by the weight of the material, causing the back of the forklift to fly up into the air. When this happened, claimant slammed his head on the roll cage above his head. After he hit his head, the material on the forklift slid off, and the forklift returned to its normal position. This caused claimant's head to be thrown back, and he slammed his head again on the forklift. Claimant testified that he had immediate pain in his head and neck. He said he had a bump on his head that he described as being 2 inches wide and 6 to 8 inches long, which claimant said was and still is very painful. The bump starts about in the middle of the top of his head, just above his forehead, and goes all the way to the back of his head.[3] He denied that he had the bump following his 2002 surgery.

Claimant said he reported the accident to his supervisor, David Wallis, and asked to see a doctor. However, Mr. Wallis instead called Jason Jenkins, respondent's assistant plant manager. Claimant said Mr. Jenkins performed a couple of tests with a pencil, felt the bump on his head, and told claimant to go home and call if he had any more problems. Claimant said he then went home and took some Tylenol. He returned to work at respondent, even though he said he continued to have a headache and neck pain every day. He testified that he constantly complained to respondent that he was continuing to have problems and asked to see a doctor.

Claimant testified that his head injuries are getting worse. He has migraines now, which he said he did not have before his head injury at respondent. Along with the migraine headaches, he has a constant, generalized headache. He testified that he vomits every day from the headache pain, and this has been going on since October 2008.

Further, claimant testified that he suffers from depression. He stated he has contemplated suicide. He thinks about suicide every day because he is not the person he used to be and because of the pain. He has anger issues and is easily agitated. He has short term memory issues, and his abstract reasoning has declined.

David Wallis testified that he no longer works for respondent, but when he did he primarily worked as a supervisor in the insert department, where he was claimant's supervisor. On the day of the forklift incident, someone told him that claimant had dropped a bundle. Mr. Wallis immediately went outside and saw a bundle of brass on the ground with the forks still under it. Claimant had gotten too many bundles on the forks and when

[3] There is no medical evidence in the record that claimant had or still has this described bump on his head.

he backed up, the load was front-heavy. A bundle dropped and broke loose, and there were bars everywhere. Mr. Wallis asked claimant if he was hurt, and claimant said no but that he had bumped his head. Mr. Wallis asked claimant if he had been wearing his seatbelt, and claimant said he was. Mr. Wallis made a visual examination of claimant's head but did not touch him. He did not see a bump, and claimant was not bleeding. Although Mr. Wallis said claimant appeared agitated, he had no signs of trauma. He said that claimant did not appear to be in shock. Claimant's concern at that point was his work performance. Mr. Wallis asked if claimant wanted to see a doctor, and claimant said he did not. Because claimant was agitated, Mr. Wallis told him to work inside the building. He said that claimant worked the rest of the day and did not go home. To Mr. Wallis' knowledge, claimant did not make any complaints about any physical problems that day. At no time later did claimant request medical care in regard to the forklift incident.

Mr. Wallis did not notice a change in claimant after the accident. He said that before the forklift incident, claimant had temperament issues. He would fly off the handle and become easily agitated. During the entire time Mr. Wallis knew claimant, claimant would become immediately enraged if counseled on conduct, safety, or taking too many smoke breaks. Mr. Wallis described it as "steroid rage–calm one second, complete rage the next second."[4]

Jason Jenkins testified that in May 2006, he was notified by Mr. Wallis that claimant had an accident with the forklift. Mr. Jenkins asked claimant if he was all right, and claimant said he bumped his head. Claimant then pulled his hair aside, and Mr. Jenkins said he had a little bump, but he did not see any redness or bleeding. Mr. Jenkins then asked claimant if he thought he needed to see a doctor, and claimant said he did not. He said a report was filled out, and claimant continued to work the rest of the day. As far as Mr. Jenkins knew, claimant made no request to see a doctor between the time of the accident and the date he saw Dr. Christensen.

Mr. Geoff Collins, respondent's plant manager, testified that he set up a re-enactment of the forklift incident, which he stated showed that the accident could not have occurred in the way claimant testified. Mr. Collins also testified the reenactment showed that claimant would not have hit his head on the forklift in the incident. Mr. Collins admitted that the person driving the forklift in the reenactment weighed about 50 pounds more than did claimant, but he said the driver in the reenactment and claimant were about the same height. Mr. Collins also admitted that the tires on the forklift had been changed since the 2006 accident, he did not know if claimant was driving on gravel or pavement when the accident occurred, and he did not know if the propane tank on the back of the forklift was full or empty on the date of the accident.

[4] Wallis Depo at 42.

Dana Brown testified that she and claimant became engaged and moved in together in 2004. Since claimant's injury on May 8, 2006, and his respiratory problem beginning June 2006, she has noticed changes in claimant, both physically and emotionally. She said it is like living with a different person. She said that now claimant has a problem remembering things. He gets confused easily and has problems putting together a thought and expressing it verbally. He used to be laid back, but now he gets agitated easily. He gets angry and raises his voice. He has had episodes of road rage. Claimant has been depressed and has made comments that he would be better off dead. One day Ms. Brown found claimant sitting on the edge of a bed with the barrel of a gun in his mouth.

Ms. Brown testified that claimant started complaining of headaches within a day or two of the forklift accident. She said that he appears to be in pain all the time and has problems sleeping. He has a headache every day. When claimant has a migraine headache, he cannot be around light or sound, and almost every time the migraine gets so bad claimant vomits. Once claimant had a migraine for three days straight and he vomited so much that blood came up. Ms. Brown said that claimant went to the hospital for that. She said claimant has been taken to the emergency room four times because of migraines and has been treated with nausea medication.

Ms. Brown testified that in the time she knew claimant before his injury at respondent, she had never witnessed him have a migraine-type headache. He did not have the constant headache he has now. He did not threaten suicide before or have trouble sleeping. She had not witnessed road rage incidents or claimant acting agitated. Before the accident, he did not appear to be confused in verbalizing a thought process or have memory problems.

Claimant was first seen by a medical provider for injuries arising from the May 2006 accident on June 16, 2006, when respondent took him to its company doctor, James Christensen, D.O. Claimant told Dr. Christensen that he was experiencing soreness to the top of his head. Dr. Christensen said that it was possible that claimant could have had some soreness if he bumped his head, but he did not report any other symptoms and the doctor could find no physical findings related to the forklift incident. But because of claimant's history of having had previous brain surgery, Dr. Christensen suggested that he see his personal physician and have a CT scan. Dr. Christensen said that claimant had an exostosis, a bony outgrowth which takes time to develop. The exostosis would have developed from a previous injury and could not have been caused, aggravated, accelerated, or intensified by a bump on the head.

Dr. Pedro Murati is board certified in physical medicine and rehabilitation, electrodiagnosis, and independent medical evaluations. He examined claimant on July 10, 2006, in regard to his two work injuries at respondent. He issued two reports, one for the closed head injury of May 8, 2006, and one for the chemical exposure claim each and every working day beginning June 9, 2006. In regard to his examination of claimant's injury of May 8, 2006, Dr. Murati said claimant's chief complaints were irritability and easy to

anger, increased memory loss, daily headaches, and right-sided neck pain. Claimant also complained of loss of balance at times with occasional dizziness but no nausea.

Dr. Murati's cerebral examination showed that claimant had good math ability, but his abstract reasoning was poor. His short-term memory was 2/3, and his mid-term and long-term memory were good. There was no nystagmus; finger to shin was good; heel to shin was good; there was no dysdiadochokinesia; and there was a negative Romberg. Dr. Murati diagnosed claimant with a cervical strain and post-concussion syndrome. He opined that the cervical strain and post-concussion syndrome were a direct result of claimant's injury of May 8, 2006, at respondent.

Dr. Murati saw claimant again on May 10, 2007. At that time, claimant's chief complaints in regard to the injuries from his May 2006 accident were daily headaches, constant neck pain, right shoulder pain, upper back pain, anger outbursts/easily agitated; and depression with suicidal thoughts. Claimant told Dr. Murati that he suffered from memory problems before his work-related accident, but the problems got worse after his accident of May 8, 2006.

Dr. Murati diagnosed claimant with neck pain secondary to cervical radiculopathy, post-concussion syndrome, suicidal ideation, and myofascial pain syndrome affecting the right shoulder girdle extending into the neck. Dr. Murati recommended that claimant have psychological counseling. He again opined that claimant's diagnoses were a direct result of his work related injury of May 8, 2006.

Dr. Murati saw claimant a third time on May 8, 2008. He got an up-dated medical history from claimant, which included psychological evaluations. After examining claimant, Dr. Murati diagnosed him with neck pain secondary to cervical radiculopathy; post-concussion syndrome; and myofascial pain syndrome affecting the right shoulder girdle extending into the cervical paraspinals, which he said were the result of claimant's May 8, 2006, injury at respondent.

Dr. Murati rated claimant's permanent partial impairment in regard to the May 8, 2006, accident as follows: For neck pain secondary due to radiculopathy, Dr. Murati opined that claimant was in Cervicothoracic diagnosis related estimate (DRE) Category III, a 15 percent whole person impairment. For post-concussion syndrome, claimant received a 5 percent whole person impairment. Dr. Murati did not rate claimant's psychiatric issues.

Dr. Murati assigned claimant permanent restrictions of rarely climbing ladders, no crawling, rarely performing above shoulder work, and no lifting, carrying, pushing or pulling above 35 pounds, occasionally lifting, carrying, pushing or pulling up to 35 pounds, and frequent lifting, carrying, pushing or pulling up to 20 pounds. Claimant should not work more than 24 inches from the body and should avoid awkward positions of the neck.

Dr. Murati reviewed a task list prepared by Karen Terrill. He found that of the 115 nonduplicated tasks on that list, claimant was unable to perform 109 for a 95 percent loss of task performing ability. The tasks were eliminated as a result of claimant's orthopedic restrictions, not the chemical exposure. Dr. Murati opined that claimant is essentially and realistically unemployable.

Dr. Matthew Henry, a neurosurgeon with Abay Neuroscience Center, saw claimant on August 23, 2006. Claimant had been seen by Dr. Abay in 2002. Claimant had developed short-term memory loss, headaches and nausea in September 2001. He was found to have a cyst in his brain. He was evaluated by Dr. Abay and underwent a cranial cyst to peritoneal shunt placement on January 18, 2002. Claimant continued to have headaches and short-term memory loss. Claimant was reassessed on April 16, 2002, at which time he was having sharp pains in the back of his head, nausea, vomiting, dizziness, and some memory problems. A CT scan was performed on April 29, 2002. Claimant was seen again on September 26, 2002, complaining of short-term memory problems. He denied headache and wanted a release to return to work. He was referred to a memory specialist. Claimant was seen again on November 12, 2002, to evaluate the bump on his head.

Claimant was not seen again in Dr. Abay's office until he was seen by Dr. Henry on August 23, 2006. Claimant told Dr. Henry he had been involved in a work-related injury where he struck his head and was having intermittent headaches, intermittent dizziness, and nausea with some depression. In Dr. Henry's evaluation, he found that claimant had some small stable fluid collections that did not appear to be causing any compression of the brain. Dr. Henry wanted to be sure there was no over-draining, so he ordered a CT scan. The CT scan revealed no damage to the shunt and not a lot of anatomic change from the CT scan done in April 2002. An MRI also did not reveal anything consistent with shunt malfunction, trauma or tumor. The MRI showed a focal area of increased signal on T2 images in the left, which may represent a simple extension of the cisterna rather than a focal abnormality in the brain stem. Dr. Henry found no significant anatomic changes that could have resulted from the forklift event and no anatomic problems that would improve with surgery.

Dr. John DeWitt, a board certified neurologist, examined claimant at the request of respondent on December 7, 2006. Claimant gave a history of the May 8, 2006, accident in which he struck his head while driving a forklift. Claimant told Dr. DeWitt that he had not been knocked unconscious and was able to finish out the workday. Claimant complained to Dr. DeWitt of feeling nervous and depressed and said he had chronic headache and neck pain. He also described himself as feeling jumpy and jittery. He had insomnia and what he described as rage attacks. Claimant also said he had tinnitus or roaring in his left ear. Claimant told Dr. DeWitt that he had previously suffered headaches and had been diagnosed as having an arachnoid cyst, for which he underwent surgery.

In terms of the neurological examination, Dr. DeWitt was not able to find any neurologic deficits of any kind that would be responsible for claimant's symptoms. Dr. DeWitt believed that claimant suffered from post-concussion syndrome as a result of his work injury. Dr. DeWitt did not believe that claimant required any additional treatment for that condition. He did not believe claimant had any impairment associated with his condition. He recommended that claimant continue to have his headaches treated by his family doctor.

Dr. Allen Parmet is board certified in occupational and aerospace medicine. He evaluated claimant at the request of respondent on February 23, 2007. At that time, claimant was not complaining of either intermittent or continuous headaches. Claimant was not complaining of any difficulties with his spine, but he did indicate he had stabbing pain over much of his head and the front of his body from the upper chest down to about the umbilicus and over much of the thoracic back. Dr. Parmet performed a standard examination with a slightly more extensive abdominal examination because he primarily was seeing claimant for gastrointestinal complaints. Dr. Parmet said the only finding he found of significance during the head examination was a shunt bulb under the scalp.

Dr. Parmet said claimant's physical examination was unremarkable. In terms of claimant's head and neck area, there was nothing that indicated to Dr. Parmet what was causing the symptoms that claimant marked on the pain chart. Claimant's cervical spine was straight, non tender and had full of range of motion. Claimant was not actively complaining of a headache. Dr. Parmet made no diagnosis of claimant in regard to his complaints concerning his May 2006 accident.

Dr. Paul Stein, a board certified neurosurgeon, evaluated claimant on October 16, 2008, at the request of respondent. Claimant complained of constant pain in his head, neck, upper back, and shoulder blades. He had severe headache constantly, and every few months the headache became extreme for up to 24 hours with light sensitivity and nausea. Claimant said he had a shunt in 2001 or 2002 because of severe headaches, and those headaches had resolved completely. Claimant said he had memory problems before his work accident but they became worse after. Claimant also complained of intermittent numbness in his right shoulder and arm and some dizziness.

Dr. Stein found that claimant had some mild decrease of rotation in the neck, but otherwise the range of motion of his neck was good. He had some local tenderness over the C6 spinous process, but no tenderness in the muscles or ligaments in the midline. Claimant had no guarding or spasm. The remainder of the examination, except for the finding of the shunt, was normal. Dr. Stein said that claimant had no neurological deficit. He found no evidence that claimant was suffering from cervical radiculopathy. He did not find any objective evidence that claimant was suffering from myofascial pain syndrome affecting either his cervical spine, trapezius or shoulder area.

Based on the AMA *Guides*,[5] Dr. Stein found claimant to be in DRE Category 1, which does not carry any functional impairment on a permanent basis. Dr. Stein had one proviso to his opinion, and that was that claimant have flexion and extension x-rays of the cervical spine so he could be certain that claimant did not have an unstable cervical spine. Those x-rays were later taken, and in Dr. Stein's January 8, 2009, report, he indicated that the x-rays showed that claimant had no instability. Therefore, Dr. Stein's opinions from his October 16, 2008, opinion were unchanged. Dr. Stein did not place any restrictions on claimant in relation to his cervical spine, which was the sole focus of his examination.

Dr. Ted Moeller is a clinical psychologist. He initially performed an independent medical examination on claimant on July 30, 2007. Claimant gave a history of his work-related accident on May 8, 2006. Dr. Moeller said claimant was angry because Dr. Christensen had not been helpful and told claimant that he did not give a CT scan to everyone who hits his head. Claimant told Dr. Moeller that he had ongoing pain that never goes away. Claimant also talked about depressive symptoms of irritability, increased response to stress, and difficulty controlling irritability. Claimant talked about feeling nervous or shaking inside and about previous suicidal thoughts. Claimant said he had placed a 20-gauge shotgun in his mouth but stopped himself from committing suicide. Claimant also told Dr. Moeller about his allergic reaction to breathing fumes and that respondent dealt with that by moving him to a different area.

Dr. Moeller gave claimant several psychological tests, after which he diagnosed claimant with major depression, recurrent, moderate, without psychotic features. He thought there was probably a co-existing dysthymic disorder that had been long-standing. He also diagnosed claimant with alcohol abuse, although claimant had reported that he stopped drinking alcoholic beverages. In reviewing the results of the tests, Dr. Moeller was initially of the opinion that claimant had genuine impairment that was at least partially attributable to the work-related injury, but he needed to continue to look at that in terms of ruling out the probability that claimant was overstating or exaggerating the impairment.

Dr. Moeller recommended treatment protocol that included an evaluation for an appropriate antidepressant. He also suggested a series of cognitive behavioral management sessions using cognitive therapy as a tool to help claimant manage and change and creatively recover from his depression. Beginning on December 19, 2007, Dr. Moeller began providing claimant with therapy. Dr. Moeller said by then he was already having questions about what was going on because claimant had difficulty talking about his symptoms from an experiential standpoint. Dr. Moeller said claimant talked about his symptoms as if he had read about them and was describing something someone had told him rather than something he experienced. He said that claimant was not enthusiastic

[5] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

about attempting to get help for the depression and pain and appeared as if someone had instructed him to cooperate.

Dr. Moeller saw claimant twice in January 2008. He last saw claimant on March 27, 2008, and said there had been no change since January. Claimant was rather argumentative because Dr. Moeller had been out of the country and had not called him to set up a telephone session. Claimant told Dr. Moeller he had been about to put a shotgun in his mouth and his wife grabbed the gun away from him. Dr. Moeller found it significant that neither claimant nor his wife called anyone, either Dr. Moeller, the hospital or the local mental health center. At the end of the session, Dr. Moeller opined that the therapy was not going to be of any assistance to the claimant.

Dr. Moeller ultimately concluded that claimant was magnifying his complaints. This conclusion was the result of the clinical interview, testing, and the therapy sessions. Because of the malingering issue, Dr. Moeller was not able to determine that there was sufficient positive indications that claimant had any issues that were caused by or exacerbated by the injury. Dr. Moeller's final diagnosis of claimant was malingering and adjustment disorder with depressed mood. Further, he thought there was sufficient data to indicate claimant had a personality disorder.

Dr. John McMaster is board certified in family practice and emergency medicine with a subspecialty in undersea and hyperbaric medicine. He was asked by either Dr. Moeller or a case manager to evaluate and treat claimant. He first saw claimant on December 19, 2007. Based on Dr. McMaster's initial evaluation, it was his clinical impression that claimant would potentially benefit from treatment for depression. He initiated a treatment regimen of Zoloft in conjunction with cognitive and behavioral therapy to be directed by Dr. Moeller. However, in subsequent visits claimant reported intolerance to the effects of the medication. Further, claimant did not comply with Dr. McMaster's request to obtain information from his prescribing provider, Janice Shippey, a nurse practitioner with Caney Clinic.

Dr. McMaster saw claimant on March 27, 2008, at which time claimant reported continued intolerance to Zoloft and said he did not believe he was getting any benefit from the medication. Claimant also reported an episode of suicidal ideation. Dr. McMaster noted that no medical care was sought at the time of the suicide attempt, which Dr. McMaster said was out of the ordinary.

Dr. McMaster's last visit with claimant was on April 17, 2008. At that time, Dr. McMaster believed that claimant had reached maximum medical benefit from his attempt to improve the symptoms for which claimant was directed to him for care. It was Dr. McMaster's opinion that the pain claimant was reporting was not related to the incident as reported to him. Instead, Dr. McMaster believed claimant was suffering from depression but did not believe the origin of the depression was related to the incident at work. Dr. McMaster could not say whether the incident at work aggravated or exacerbated claimant's

depression because he did not have the details of the incident and a time line. Based on Dr. McMaster's experience and utilization of the AMA *Guides*, he believed claimant had no impairment as a result of the occupational incident.

Dr. John Pro is board certified in general psychiatry and geriatric psychiatry. He evaluated claimant on July 1, 2008, at the request of claimant's attorney. In the course of the evaluation, he reviewed claimant's records and interviewed claimant and claimant's fiancee. After completing his psychiatric evaluation, he diagnosed claimant with major depressive disorder, traumatic brain injury, and alcohol abuse. He believed that the May 8, 2006, accident was the cause of claimant's major depression and was responsible for the aggravation of claimant's brain injury.

Dr. Pro recommended that claimant receive psychiatric treatment and that his fiancee be involved in the treatment. Dr. Pro said claimant has a need to be in therapy so someone can assess his suicidal behavior. For claimant's headaches, he also recommended a trial of Cymbalta, which is an antidepressant helpful in pain and depression, as well as other drugs to help stabilize claimant's mood and help with his headaches. Dr. Pro said claimant would benefit from seeing a psychiatrist who is capable of dealing with patients with organic brain disease, chronic pain and depression. He also suggested claimant have marital therapy and neuropsychological testing.

Dr. Pro opined that because of claimant's deficits, claimant is not employable. Of his symptoms, claimant's memory loss, irritability and depressed mood are the most limiting in terms of claimant's ability to work. Dr. Pro acknowledged that claimant had memory loss before the work accident, but he believes claimant's memory loss has become more of a problem. He acknowledged he has no way of judging what claimant's memory was before the accident. Dr. Pro said that claimant's head injury is not the only cause of his memory loss. He believed that claimant's minor head injury provoked depression, which then affected his memory and made him preoccupied with being unable to remember well.

Dr. Pro did not see any evidence during his evaluation that claimant was malingering. Dr. Pro testified that he relies on and has confidence in his ability to assess whether a person is malingering by talking to them, getting information from the family, and gleaning information from the records.

Dr. Pro rated claimant as having a 60 percent whole person psychological impairment. Of that 60 percent, he believes 40 percent is directly attributable to the May 8, 2006, work injury. His impairment rating is based on the AMA *Guides*. Dr. Pro arrived at the 60 percent rating based on his knowledge, experience and training of the AMA *Guides*. The 20 percent preexisting rating is based on claimant's past impairment related to his loss of jobs when he was a teenager, his alcohol abuse, and his problems with fighting. Dr. Pro

said claimant's impairment is not due solely to his severe depression but is attributable to the aggregate of his symptoms–his memory loss and headaches, as well as depression.

After he was fired from respondent, claimant went to work at a farm agricultural business. He was only able to work there about 10 days because he was not physically able to do the work. He then went to work at Casey's General Store making pizza. He worked there from 10 days to 2 weeks. Claimant said he lost his job at Casey's because of his headaches and because he was unable to sleep. Claimant has applied for Social Security disability, and his case is pending. He does not believe he can work because he sits in his recliner all day and most of the time he cannot move without becoming nauseated and vomiting. He has a lot of neck pain and his head always hurts. Because he does not sleep, he is constantly tired.

Karen Terrill, a rehabilitation consultant, interviewed claimant by telephone on three occasions. She did not have the benefit of claimant's social security work history to help him list his 15-year work history. Claimant gave her a detailed job listing, and she helped him break down each job into essential job tasks. They made a list of 115 tasks that claimant had performed in the 15-year period before his injury.

Docket No. 1,029,603; June 9, 2006, accident (exposure to oil)

Claimant testified that on June 9, 2006, he was working a machine in the insert department and started getting light-headed, feeling sick, sweating, and having chest pains. He told his supervisor, Mr. Wallis, and was instructed to go over to a picnic table 15 feet away and to return when he felt better. About 15-20 minutes later, claimant told Mr. Wallis he was feeling better. He returned to working on the machine, but after about 5 minutes he started sweating, having chest pains and getting short of breath. He talked to Mr. Wallis again, saying he thought he was having a heart attack, and he was again told to sit by the picnic table. Claimant said Mr. Wallis wanted to call an ambulance, and claimant said he wanted an ambulance called.

Mr. Wallis testified that claimant had been off work for a suspension from June 5 through June 7, 2006. On June 9, 2006, claimant had a respiratory reaction to something. Claimant started work at 7 a.m. and at 9 a.m. Mr. Wallis noticed claimant was flushed and was sweating heavily. Claimant appeared to be having an allergic reaction. Mr. Wallis sent claimant outside to get some air. Mr. Wallis took claimant's pulse, and it was racing. Claimant told Mr. Wallis that while he was on suspension, he was treated for allergies and had received an allergy shot. Mr. Wallis also made a note that claimant was on anxiety medicine. An ambulance was called because respondent was not set up for that kind of medical problem.

Mr. Jenkins testified he received a call from Mr. Wallis on June 9, 2006, asking him to come to the insert shop. Mr. Jenkins came over immediately. As he approached,

claimant was sitting outside on a picnic table bench. Mr. Wallis told Mr. Jenkins that claimant was complaining that he was having trouble breathing. Claimant had just come off of a suspension from work, and claimant told Mr. Wallis that during his suspension he had been put on some new medication for allergies as well as some type of anxiety medication. Claimant had told Mr. Wallis he thought that might be part of the problem.

Mr. Jenkins said he walked up to claimant, who was sitting and smoking a cigarette. He asked claimant what the problem was, and claimant said he was having trouble breathing. Mr. Jenkins pointed to claimant's cigarette and asked if he thought that might have anything to do with his breathing problems. Claimant did not respond to that. Mr. Jenkins asked claimant if he thought he needed to go to the hospital, and claimant said he thought he needed to see a doctor. However, the HR manager at the time, Jeff Atchison, said it would be a good idea to call an ambulance instead, so an ambulance was called. Mr. Jenkins testified that by the tone of claimant's voice and the way he acted, he did not think there was any emergency. But he wanted to be sure the right thing was done for claimant. Had Mr. Jenkins felt there had been an emergency, he would have immediately called the ambulance.

Claimant said while he was at the hospital, he was given a breathing treatment and was then released.

Part of claimant's job of working in the insert department required him to work with a coolant oil for the machines. Claimant said the oil is everywhere. It is in the air, and it drips off the ceiling fan. The oil had fumes, which claimant would breathe in. Claimant said he was exposed to this oil product for a year and a half before the June 9, 2006, incident. Claimant said that when he was in the emergency room on June 9, 2006, the doctor told him to look for another job or get some kind of medication that would help him work with the oil, or in the alternative he should wear a respirator.

Claimant was sent to Dr. Christensen by respondent on June 12, 2006. Dr. Christensen's notes indicate that claimant began developing a respiratory problem at work. Dr. Christensen's notes indicate a diagnosis of sensitivity to the aerosolized oil that caused bronchial constriction.

The next time claimant saw Dr. Christensen was on June 16, 2006. Claimant testified that samples of the oil coolant were injected into his arm, and his arm swelled up. Dr. Christensen, however, testified that he used an alternative medicine technique to perform the allergy testing. He tested the strength in claimant's shoulder muscles. Then he had claimant hold a vial of the oil sample in his hand. Dr. Christensen then retested claimant's shoulder strength. Dr. Christensen said that in this test, if the patient's strength tests weak, they are allergic to the substance they are holding. If they remain strong, they are not allergic. Dr. Christensen's notes indicate that claimant was allergic to all three oil samples. Other than the strength testing, Dr. Christensen did no other testing on claimant. Dr. Christensen's notes indicate that claimant should not remain in a work area that has

oil aerosolized because he was allergic to it. Claimant was not given any treatment for the oil allergy, and Dr. Christensen has not seen claimant since June 16, 2006.

After receiving the restriction from Dr. Christensen, respondent transferred claimant from the insert department to the barcode department. Claimant, however, testified he was still exposed to the solvent that had caused him to have an allergic reaction. He said he voiced complaints to his employer, and at times he was unable to work his entire workday. As a result of the oil exposure, claimant still has a lot of mucus, he has diarrhea, his stomach hurts, and he has shortness of breath. When he has difficulty breathing, he becomes anxious and has difficulty walking more than about a block.

Claimant testified that before his exposure to oil at respondent, he did not have any gastrointestinal problems. He did not remember if he had a history of abdominal pain or ulcers. He did not have a history of diarrhea or of dark or bloody stools.

Jason Moore is the human resource manager of respondent. Before that, he was the packaging manager. Mr. Moore said that claimant transferred out of the insert department and came to work in the barcoding area on June 26, 2006. At the time, Mr. Moore knew claimant was having health problems and had been transferred to barcoding to alleviate those problems. Mr. Moore knew the health problems involved exposure to oil while he was working in the insert department. Mr. Moore said the barcode job is an indoor job, and there is air conditioning. There is no use of aerosolized oil in that area. The barcoding process consists of an ink jet printer that sprays information on the fitting as it goes by. The ink has to adhere to the plastic, and Mr. Moore said if there was any kind of oil residue on the parts, the ink would not adhere. After claimant's transfer to the barcoding department, he continued to have health problems. Claimant left work several times, complaining that he had headaches, was dizzy, and was faint. Mr. Moore said that at some point claimant received a medical restriction indicating he should be under an air conditioning vent. Respondent was able to accommodate that restriction.

Mr. Moore said he went with claimant to Dr. Christensen's office to have him evaluate a lump on claimant's head and to see if claimant was allergic to oil. Mr. Moore was present when Dr. Christensen performed the alternative approach to checking claimant's allergy to oil, and he had brought with him samples of various kinds of oil. Mr. Moore said that Dr. Christensen had claimant lay on the table on his back, and he raised claimant's arm straight out in front of him, perpendicular to his body. Then he told claimant to hold his arm in that position, and he grabbed claimant's arm and pulled it down towards his legs. Then Dr. Christensen placed a sealed bottle of oil in claimant's hand and put his hand in the same position with his arm perpendicular. He pulled claimant's arm towards his legs at that point. Dr. Christensen repeated this process with all the bottles of oil Mr. Moore had brought. Then Dr. Christensen told claimant that he was allergic to the oil. Mr. Moore questioned Dr. Christensen's method of determining that claimant was allergic to the oil, but Dr. Christensen told him that if a person is holding a substance he is allergic

to, it makes his muscles less strong. Dr. Christensen did not perform any kind of a needle test.

Geoff Collins is respondent's plant manager. He said the insert department of respondent is a machining operation for brass that makes an insert that plastic is molded around to make a sprinkler head. In 2006, the insert department with the brass machining would be an area having an aerosolized oil mist.

Mr. Collins said that claimant was transferred from the insert department to the main plant because Dr. Christensen indicated that claimant was allergic to oil and needed to be away from the area that involved exposure to aerosolized oil. Dr. Christensen was the company doctor at the time. Claimant was moved to an area where there was no oil and was put in an air conditioned area. Mr. Collins was aware that claimant had gone home a few times because of headache after his transfer to the main plant but before he was terminated.

On August 2, 2006, Mr. Collins joined a conversation claimant was having with his supervisor, Travis Carson. Mr. Collins said claimant was extremely irritated and at one point claimant called Mr. Collins a liar. Based on the way the conversation escalated, Mr. Collins chose to terminate claimant. Mr. Collins said that before August 2, 2006, it was respondent's plan to allow claimant to continue working in the barcoding department.

Claimant testified that the barcode line he worked on caused him to be exposed to a solvent. Mr. Collins said respondent used a cleaning solution to clean the head of a printer. The cleaning solution would be used once a shift, typically at the beginning or end of a shift. The solvent would be approximately 2 or 3 feet away from the operator, but the operator would be able to smell it in the area. The operator would not be able to physically touch the solution.

Dr. Daniel Doornbos, who is board certified in pulmonary disease and internal medicine, examined claimant on August 10, 2006, at the request of respondent. Dr. Doornbos was asked to perform an independent medical and pulmonary evaluation on claimant regarding respiratory symptoms he alleged were caused by exposure to workplace chemicals. Claimant's patient profile showed that he smoked a pack of cigarettes a day for 19 years and continued to smoke to the day of his examination. He used alcohol on occasion. He had a past history of using methamphetamine and cocaine, but had not done so for 10 years prior to the appointment. Claimant drank a pot of coffee a day. Claimant had a history of peptic ulcer disease, irritable bowel syndrome, and chest pain, as well as a forklift accident at work.

Upon examination, Dr. Doornbos found claimant's nasal membranes were a little irritated, his throat was slightly irritated, his lungs were clear to auscultation listening, and he did not have any wheezing. Dr. Doornbos did a chest x-ray and a pulmonary function test. The chest x-ray was normal. The pulmonary function test was mostly normal with

mildly reduced diffusing capacity. Airflow through the lungs was normal, and lung volumes were normal.

Dr. Doornbos opined that claimant was suffering from irritation of his respiratory system due to a combination of the oil inhalation and smoke inhalation. He did not believe that the inhalation of the oil mist had led to permanent damage to his lungs, or at least not enough to qualify for a particular disability. Dr. Doornbos did not give a disability rating, but in looking at the AMA *Guides*, claimant's normal spirometry and normal pulmonary function test would not go along with any substantial level of impairment. In addition, Dr. Doornbos believed claimant's continued smoking sufficiently muddied the waters so that he could not state that claimant had any ongoing damage after having not been exposed to the oil for a period of time. Dr. Doornbos opined that if claimant was in the "workplaces and environments where he was exposed to any inhaled irritant, it would add to the irritation that he chronically had from smoking, and that would probably cause the temporary worsening of his lung function during the time that he was being exposed," but he did not believe claimant had permanent damage caused solely by being exposed to the oil mist.[6] Dr. Doornbos said that as a result of claimant's condition, he would need to be provided with an appropriate mask or other protection, but not more than would be required by OSHA regulations that would be applied to any worker.

Dr. Doornbos said that:

> . . . although at the time of exposure he had irritation to his mucous membranes, which is a known side effect of those known irritants, that after the exposure had ceased, then after a period of healing had occurred he should have been back to his baseline before as he would have been if this had never happened.[7]

Dr. Doornbos said that claimant probably was in need of treatment. He encouraged claimant to get with his primary care provider to work on his peptic ulcer disease. Dr. Doornbos sent a note to claimant's primary care physician stating that it would probably be a good idea if claimant cut down on his caffeine intake. He did not specifically tell claimant that he needed to quit smoking but thought that would be obvious. Although at some point claimant may or may not need an inhaler, he did not believe it necessary to prescribe an inhaler or tell claimant to see his physician to get an inhaler. He believed that life-style changes in terms of reduction of caffeine intake and medications to help his acid reflux problem and peptic ulcer disease might benefit claimant.

Although claimant's medical record said that he was allergic to three samples of oil, the record did not give any details so that Dr. Doornbos could determine what was meant by allergy. Dr. Doornbos said that it appeared Dr. Christensen did some sort of testing, but

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[6] Doornbos Depo. at 13.

[7] Doornbos Depo. at 17-18.

Dr. Doornbos could not say whether it was a standard or adequate test without more information. Without more information, he could not say whether he would agree or disagree with Dr. Christensen's assessment. He could not say that claimant could not be in any area where there was any oil in the air, no matter how minute the quantity. Dr. Doornbos said that in order to know if claimant was an individual that could not be around even minuscule amounts of aerosolized oil, he would have to have formal allergy testing by an allergist or have an antigen challenge where, under laboratory conditions with pulmonary function testing equipment standing by, he would inhale known microscopic quantities of the substance while the results are observed on the pulmonary function equipment.

In regard to Dr. Murati's July 10, 2006, examination of claimant for his claim of chemical exposure, claimant's chief complaints were coughing up yellow/clear mucus, wheezing and shortness of breath, abdominal pain, and diarrhea. Claimant told Dr. Murati that for eight or nine months he had been working around an aerosolized oil/coolant mixture. He was taken to the emergency room on June 9, 2006, because of difficulty breathing. He was given a breathing treatment and was released. Claimant later began to experience symptoms of abdominal pain, and an EGD showed he had four ulcers. Claimant was told by a doctor at Jane Phillips Medical Center emergency room that the ulcers were due to the oil exposure. Claimant told Dr. Murati he then began to experience frequent diarrhea.

Dr. Pedro Murati, on July 10, 2006, found no wheezing in his examination of claimant. Claimant's heart examination was normal. Dr. Murati diagnosed claimant with an oil allergy, abdominal pain, and diarrhea secondary to an unknown etiology. He opined that claimant's oil allergy is secondary to an injury at work beginning June 9, 2006. He recommended that claimant cease smoking and be evaluated by a gastroenterologist. Dr. Murati also recommended that claimant not have any contact with allergens.

Dr. Murati saw claimant again on May 8, 2008. Dr. Murati diagnosed him with an oil allergy, which he again said was the result of claimant's exposure at work each and every working day beginning June 9, 2006. For the oil allergy, Dr. Murati rated claimant as having a 3 percent whole person impairment. Dr. Murati said there is no clear-cut table in the AMA *Guides* that gave a rating for an oil allergy, but he thought 3 percent was a reasonable number. He did not rate claimant's gastrointestinal issues. Further, he did not rate claimant's psychiatric issues. Dr. Murati said that claimant should avoid contact with oils and solvents.

Dr. Murati agreed that he had no information regarding the type of oil that claimant was exposed to, nor any information about what kind of chemical properties the oil had. He did not know what type of testing Dr. Christensen used to determine claimant's allergy. He did not have any medical records from any provider to indicate whether claimant may have suffered from any of his symptoms before he began working around the oil. Dr. Murati did not know what was causing claimant's abdominal pain and diarrhea. He said

that claimant's complaints of wheezing, shortness of breath and coughing up yellow to clear mucus could be caused by his smoking. Dr. Murati did not have any medical records to document the extent to which claimant had memory loss before the accident

Dr. Murati stated that based only on the restrictions he gave claimant, there probably would be some jobs that claimant could perform.

In Dr. Parmet's examination of claimant on February 23, 2007, claimant reported an occupational exposure to cutting oil mist, but Dr. Parmet could not find any abnormalities attributable to that exposure in his examination. Dr. Parmet believed that claimant had acid peptic disease and probably also had diverticulitis.

Claimant told Dr. Parmet that he had been exposed to cutting oil, primarily in the form of mist. Dr. Parmet said it would be hard to inhale very much of the total product even over an 8-hour shift. He said he did not think claimant absorbed much, but what he did could have entered the gastrointestinal tract. The oil claimant inhaled is a type similar to mineral oil occasionally given to induce bowel movements. What claimant would have inhaled would be a lot less than a normal dose given to patients to induce a bowel movement. Dr. Parmet said there should not be any effect from inhaling the oil other than inducing bowel movement during the period of exposure.

Dr. Parmet said that claimant's medical records indicated he had irritable bowel syndrome and ulcer disease in the past. He also said that much of claimant's current symptoms resemble ulcer disease or acid peptic disease, and irritable bowel syndrome is similar in symptomology to diverticulosis. He reviewed claimant's diet and said that claimant is a good risk for diverticulosis because he had a low fiber diet.

Dr. Parmet said he could find no causal relationship between claimant's acid peptic disease or diverticulosis that could be attributed to his ingestion of cutting oils. Once claimant is no longer in an environment where the cutting oils were being breathed, he would no longer have symptoms attributable to that ingestion. By the time Dr. Parmet examined claimant in February 2007, he would expect that any symptoms claimant was suffering when he evaluated him would not be related to the ingestion of the mineral oil. Dr. Parmet did not believe that claimant was suffering any permanent impairment of function as a result of his exposure to cutting oils in the workplace at respondent.

PRINCIPLES OF LAW

K.S.A. 2009 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends."

K.S.A. 2009 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

An employer is liable to pay compensation to an employee where the employee incurs personal injury by accident arising out of and in the course of employment.[8] Whether an accident arises out of and in the course of the worker's employment depends upon the facts peculiar to the particular case.[9]

The two phrases arising "out of" and "in the course of" employment, as used in the Kansas Workers Compensation Act, have separate and distinct meanings; they are conjunctive and each condition must exist before compensation is allowable.

> The phrase "out of" employment points to the cause or origin of the accident and requires some causal connection between the accidental injury and the employment. An injury arises "out of" employment when there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is required to be performed and the resulting injury. Thus, an injury arises "out of" employment if it arises out of the nature, conditions, obligations, and incidents of the employment. The phrase "in the course of" employment relates to the time, place, and circumstances under which the accident occurred and means the injury happened while the worker was at work in the employer's service.[10]

An accidental injury is compensable under the Workers Compensation Act even where the accident only serves to aggravate a preexisting condition.[11] The test is not whether the accident causes the condition, but whether the accident aggravates or accelerates the condition.[12] An injury is not compensable, however, where the worsening or new injury would have occurred even absent the accidental injury or where the injury is shown to have been produced by an independent intervening cause.[13]

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[8] K.S.A. 2009 Supp. 44-501(a).

[9] *Kindel v. Ferco Rental, Inc.*, 258 Kan. 272, 278, 899 P.2d 1058 (1995).

[10] *Id.* at 278.

[11] *Odell v. Unified School District*, 206 Kan. 752, 758, 481 P.2d 974 (1971).

[12] *Woodward v. Beech Aircraft Corp.*, 24 Kan. App. 2d 510, Syl. ¶ 2, 949 P.2d 1149 (1997).

[13] *Nance v. Harvey County*, 263 Kan. 542, 547-50, 952 P.2d 411 (1997).

ANALYSIS

Claimant was injured on May 8, 2006, when he struck his head while operating a forklift. As a result of that accident, claimant sustained a concussion and cervical strain. Claimant also suffered from post-concussion syndrome. He has no rateable permanent impairment of function from these conditions and is not in need of additional medical treatment at this time for either the cervical strain or the post-concussion syndrome. Furthermore, although claimant has symptoms that have been diagnosed as psychological conditions, including depression, those conditions are not directly attributable to the physical injuries he suffered on May 8, 2006. As such, claimant is not entitled to an award of either permanent partial or permanent total disability compensation in Docket No. 1,029,602. Claimant is entitled to payment of his past authorized medical expenses and unauthorized medical expenses up to the statutory maximum. Future medical treatment may be awarded upon proper application to and approval of the Director.

In Docket No. 1,029,603, claimant has failed to prove that he suffered either personal injury by accident or an occupational disease as a result of his exposure to oil and fumes at his job with respondent. The incident on June 9, 2006, resulted in temporary symptoms which may or may not have been due to anything claimant came in contact with at work. The record does not establish a direct causal connection between claimant's employment with respondent and his pulmonary, digestive or other physical or psychological conditions.

CONCLUSION

(1) & (2) Claimant suffered personal injury by an accident that arose out of and in the course of his employment with respondent on May 8, 2006, in Docket No. 1,029,602. Claimant does not have any permanent disability or permanent impairment of function as a result of that accident.

(3) & (4) Claimant did not suffer personal injury by accident or an occupational disease as a result of exposure to oils, chemicals or fumes at work on June 9, 2006, or thereafter in Docket No. 1,029,603.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Thomas Klein dated January 21, 2010, is reversed as to the finding of a permanent total disability in Docket No. 1,029,602. The ALJ's finding of no permanent impairment in Docket No. 1,029,603 is affirmed. Claimant is denied any award of compensation in Docket No. 1,029,603.

IT IS SO ORDERED.

Dated this _____ day of April, 2010.

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BOARD MEMBER

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BOARD MEMBER

_____
BOARD MEMBER

c: William L. Phalen, Attorney for Claimant
Kendall R. Cunningham, Attorney for Respondent and its Insurance Carrier
Thomas Klein, Administrative Law Judge